STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G125	A. BUILDING _____ B. WING _____	11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	3000 BAILEY LN EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This visit was for an extended recertification and state licensure survey. Dates of Survey: November 10, 12, 13, 14, 17 and 18, 2014. Provider Number: 15G125 Aims Number: 100248730 Facility Number: 000662 Surveyor: Mark Ficklin, QIDP. These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed November 25, 2014 by Dotty Walton, QIDP.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review for 1 of 4 sampled clients (#2), the facility's governing body failed to exercise general policy and operating direction over the facility in regards to ensuring client #2 received identified supervision and treatment (client #2's choking protocol), a timely investigation of client neglect and identified staff re-training needs (client risk plans, diets, reporting incidents) were addressed in a timely manner. Findings include:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 104	Continued From page 1 1. The facility's governing body failed to implement written policy and procedures to provide services (diet supervision, reporting incidents, staff re-training) to prevent neglect of client #2. Please see W149. 9-3-1(a)	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed for 1 of 4 sampled clients (#2), to meet the Condition of Participation: Client Protections, by failing to implement written policy and procedure to prevent neglect of client #2 in regards to: not providing an identified pureed diet to prevent choking, did not implement client #2's choking protocol to immediately call 911, failure to immediately notify the nurse, administrator and guardian, failure to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, failure to immediately start an investigation and failure to timely address identified staff re-training needs. Findings include: See W149. The facility failed to implement written policy and procedures to prevent neglect of client #2 in regards to: implementation of supervision of client #2 (diet plan and choking protocol) to prevent client #2 from choking and to ensure	W 122		

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W 122	Continued From page 2 timely reporting, investigation and staff re-training was completed. See W153. The facility failed to ensure the facility administrator and BDDS were immediately notified of the alleged neglect (choking incident) of client #2.	W 122		
W 148	9-3-2(a) 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed for 1 of 2 reviewed facility investigations (client #2), to promptly inform client #2's guardian of a choking incident that required a visit to the emergency room. Findings include: Record review of the facility's incident reports was done on 11/12/14 at 9:14a.m. An incident report on 8/8/14 indicated client #2 had been given the wrong textured diet (did not receive pureed as ordered) during supper on 8/7/14 and client #2 choked. The incident report indicated client #2 received 5 back blows from staff and then client #2 vomited the food. The incident report indicated the group home staff informed the facility nurse of the 8/7/14 choking incident on the evening of	W 148		

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W 148	Continued From page 3 8/8/14 and client #2 was sent to the emergency room for follow up care. The 8/9/14 state reportable incident report indicated client #2's guardian was notified of this incident on 8/9/14. The facility's 8/12/14 investigation report indicated the guardian was notified on 8/14/14. There was no written documentation to verify the guardian was contacted on 8/9/14 and/or on 8/14/14. Record review for client #2 was done on 11/13/14 at 2:14p.m. Client #2's 5/3/14 individual support plan (ISP) indicated client #2's mother was his guardian. Interview of professional staff #1 on 11/12/14 at 11:01a.m. indicated client #2 had a guardian. Staff #1 indicated there was no documentation to ensure if client #2's guardian had been contacted on 8/9/14 or on 8/14/14. Staff #1 indicated the guardian should have been contacted immediately after the incident on 8/7/14.	W 148		
W 149	9-3-2(a) 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed for 1 of 2 allegations of client neglect reviewed (client #2), to implement policy and procedures to ensure allegations of neglect were immediately reported to the administrator, Bureau of Developmental Disabilities Services (BDDS), and guardians; and failed to ensure timely completion of identified staff re-training needs to	W 149		

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prevent reoccurrence.

Findings include:

Record review of the facility's incident reports was done on 11/12/14 at 9:14a.m. The following reports were reviewed:

1) An incident report dated on 8/8/14 indicated client #2 had been given the wrong textured diet (did not receive pureed as ordered) during supper on 8/7/14 and client #2 choked (on 8/7/14). The incident report indicated client #2 received 5 back blows from staff and then client #2 vomited the food. The incident report indicated client #2 had received food that was "not pureed correctly and corn was not pureed at all." The incident report indicated the facility nurse wasn't informed of the choking incident until the evening of 8/8/14 and client #2 was sent to the emergency room (by the nurse) for follow up care on 8/8/14 for the 8/7/14 choking incident. Client #2 returned to the group home on 8/8/14 with an 8/8/14 Medical Consult Report that indicated "no difficulty with swallowing, no cough, continue pureed diet and watch for fever, cough." The nurse had documented on 8/8/14 that the facility administrator was informed (on 8/8/14) of the 8/7/14 choking incident. The facility had documented the 8/7/14 choking incident had been reported to BDDS on 8/9/14. The facility's 8/9/14 BDDS report indicated the guardian wasn't contacted until 8/9/14.
The facility's investigation of the 8/7/14 incident of neglect (client #2 given wrong texture diet and choked) was not started until 8/12/14. The 8/12/14 investigation was completed on 8/14/14. The investigation summary indicated client #2 "choked because some of his food was not

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pureed." The 8/14/14 investigation summary included the following recommendations: "Retrain all staff on incident reporting; Retrain on all diets and high risk plans; Retrain on nursing on call procedures."

Record of staff training was done on 11/12/14 at 2:00p.m. The facility had the following documented staff training completed on 9/2/14, in response to the 8/14/14 client #2 neglect recommendations: All diet plans and whom to call if questions; staff must call the on call nurse of all medical incidents; staff must puree client #2's food and retrained on how to puree food to proper consistency; staff are to call 911 (for emergency assistance) for all choking episodes before contacting the nurse.

Record review for client #2 was done on 11/13/14 at 2:14p.m. Client #2's 11/7/14 physician's orders indicated client #2 was on a pureed diet. Client #2 had an individual support plan (ISP) dated 5/3/14. The ISP indicated client #2 had a guardian. The ISP indicated client #2 was on a pureed diet and had a High Risk Plan (HRP) for "Potential for Choking." The choking HRP indicated: staff will provide pureed diet per physician's order; should choking occur staff will immediately call 911, begin life saving techniques learned in CPR (Cardio Pulmonary Resuscitation) training and notify nursing.

The facility's policy and procedures were reviewed on 11/13/14 at 9:02a.m. The policy (undated) "Procedures Abuse/Neglect/Exploitation Death Incident Reporting and Investigation" indicated its purpose to "ensure that all allegations of Abuse/Neglect/Exploitation and Death are

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reported and investigated as required by regulations, local, state, federal guidelines. Any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated." The policy indicated Employee responsibilities as: "Determine need for medical and/or law enforcement authorities. Immediately call 911 or local authorities when imminent danger is present. Provide support as needed (medical, emotional). Immediately notify the home manager, QMRP (Qualified Mental Retardation Professional) and nurse for additional actions." The policy indicated the program director would contact the guardians and ensure client safety and put protective and preventative measures in place immediately. The facility was to ensure that documentation of protective and preventative measures are submitted to Quality Assurance within 5 days of the report of the incident. The policy indicated the facility Quality Assurance employee would report the incident to BDDS within 24 hours. The facility's 911 undated policy indicated "Do not ever call the nurse first if the following conditions are present. Pick up the phone and dial 911." The list of conditions included "choking."

Professional staff #1 (nurse) was interviewed on 11/12/14 at 11:01a.m. Professional staff #1 indicated the facility staff had failed to follow the facility's policy and procedures in regards to client #2's 8/7/14 choking incident. Professional staff #1 indicated the group home staff should have called 911 on 8/7/14 at the time of the choking incident. Staff #1 indicated that also on 8/7/14 the nurse, guardian and the administrator should have been notified. Staff #1 indicated an incident report should have been completed on 8/7/14. Staff #1 indicated BDDS should have been notified within

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W 149	Continued From page 7 24 hours. Staff #1 indicated the facility's investigation should have started immediately after the facility was aware of the choking on 8/8/14. Staff #1 indicated the 8/14/14 identified recommendations for staff re-training should have been completed prior to 9/2/14.	W 149		
W 153	9-3-2(a) 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed for 1 of 6 facility reportable incidents (client #2) reviewed, to immediately report an allegation of neglect to the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. Findings include: Record review of the facility's incident reports was done on 11/12/14 at 9:14a.m. An incident report dated on 8/8/14 indicated client #2 had been given the wrong textured diet (did not receive pureed as ordered) during supper on 8/7/14 and client #2 choked (on 8/7/14). The incident report indicated client #2 received 5 back blows from staff and then client #2 vomited the food. The incident report indicated the facility nurse was informed of the choking incident on the evening	W 153		

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W 153	Continued From page 8 of 8/8/14 and client #2 was sent to the emergency room for follow up care on 8/8/14 for the 8/7/14 choking incident. The nurse had documented on 8/8/14 that the facility administrator was informed (on 8/8/14) of the 8/7/14 choking incident. The facility documented the 8/7/14 choking incident had been reported to BDDS on 8/9/14. Professional staff #1 was interviewed on 11/12/14 at 11:01a.m. Professional staff #1 indicated the above identified incident of neglect by direct care staff to client #2 had not been immediately reported to the administrator and BDDS. Staff #1 indicated the incident of neglect took place on the evening of 8/7/14 and was not reported to the administrator until the evening of 8/8/14 and to BDDS on 8/9/14. Staff #1 indicated all allegations of abuse/neglect should be immediately reported to the administrator and BDDS. 9-3-1(b)(5) 9-3-2(a)	W 153		